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A Qualitative Evaluation of an Inpatient Nursing Intervention for Depressed Elderly: The Systematic Activation Method

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PURPOSE: This article describes the evaluation of the implementation of a nursing intervention, that is, the Systematic Activation Method (SAM), among inpatients with late life depression (LLD).

METHODS: A qualitative study in four clinical units for old age psychiatry.

RESULTS: We identified facilitators and barriers relating to patient and nurse characteristics, as well as to contextual factors, from the perspective of mental health nurses. The nature of the LLD and the quality of the therapeutic relationship were major aspects that affected the implementation of the SAM.

PRACTICE IMPLICATIONS: Given the complexity of the implementation process, careful supervision and monitoring, with the active participation of management and the multidisciplinary team, are necessary.

The prevalence of late life depression (LLD) varies from 0.9% to 9.4% in private households and from 14% to 42% in institutional settings (Djernes, 2006). LLD is the third leading contributor to the global burden of disease (World Health Organization, 2008). Persons with LLD are particularly vulnerable to deterioration in quality of life (Doraiswamy, Khan, Donahue, & Richard, 2002). The most common treatment for patients with LLD is a combination of medication and psychological interventions, provided in outpatient or inpatient treatment settings (National Institute for Health and Clinical Excellence [NICE], 2009). A recent meta-analysis of psychotherapy in depressed inpatients indicates that psychological treatments have a small but significant effect on depression (Cuijpers et al., 2011). Although the results are promising, the actual implementation of these treatments is complex because—within the Dutch healthcare system, but probably in other countries—psychotherapists are not usually available to

systematically treat all patients. An alternative solution could be the implementation of psychological interventions by nurses. The overall assumption in implementation research is that when an intervention can be executed relatively easily, chances are higher that it will actually be used in routine practice (Francke, Smit, De Veer, & Cristiaen, 2008).

Research shows that behavioral activation (BA) is a highly effective treatment modality in major depressive disorder (MDD; Cuijpers, Van Straten, & Warmerdam, 2007). It is relatively easy to execute and is useful for mental health nurses, as activation is an important focus in nursing care for patients with MDD. Therefore, we developed BA as a brief structured course to make it suitable for inpatient nursing care for patients with LLD. The primary focus of the treatment is on activating the patient, and it is therefore called the Systematic Activation Method (SAM). The SAM focuses on increasing positive reinforcement (e.g.,

pleasant activities), with the ultimate aim of achieving an improvement in the patient's mood (Clignet, van Meijel, van Straten, Lampe, & Cuijpers, 2011).

In previous research, most of the barriers to implementing evidence-based interventions were ascribed to three factors. First, there are factors related to the healthcare workers (e.g., nurses), such as a negative attitude toward the intervention, resistance to scientific research, and lack of knowledge and awareness of available evidence (Fisher, 2014; Forsner et al., 2010; Francke et al., 2008). Second, patient characteristics influence the implementation of evidence-based guidelines, such as lack of knowledge, skills, or motivation (Francke et al., 2008). And finally, contextual aspects play a role, such as lack of time, insufficient support from management, and lack of autonomy in decision-making among nurses (Fisher, 2014; Francke et al., 2008; Forsner, Hansson, Brommels, Åberg Wistedt, & Forsell, 2010; Wensing et al., 2014).

Although scientific knowledge concerning the implementation of evidence-based interventions (including psychological interventions) in nursing practice is growing, implementation studies in the field of old age psychiatry are scarce (Ekers et al., 2014; Cuijpers et al., 2011). It is thus unclear which implementation factors are most relevant to this specific population. Our assumption is that the nature of LDD and age-related factors require specific attention in the implementation of psychosocial interventions.

Therefore, the aim of this study is to explore the nurses' perceptions of the barriers and facilitators in the implementation of an intervention (SAM) in mental health nursing care. Barriers and facilitators are described on the level of nursing staff and patients, and in the context of care provision.

Methods

Design

We conducted a qualitative study, using a questionnaire and qualitative group interviews with the nurses who participated in the experimental condition of a cluster-randomized controlled trial (RCT) on the effectiveness of the SAM intervention (Clignet, van Meijel, van Straten, & Cuijpers, 2012). The RCT was carried out in 10 units for elderly psychiatry in seven psychiatric hospitals throughout the Netherlands. Five units were randomized to the control condition (care-as-usual), the other five to the experimental condition in which the SAM intervention was implemented. The study was performed in accordance with the consolidated criteria for reporting qualitative research (COREQ) criteria (Tong, Sainsbury, & Craig, 2007).

Settings

All participating units were specialized in the care and treatment of elderly patients (≥ 60 years) with severe psychiatric disorders. The SAM intervention was added to the usual treatment programs, which consisted of psychological treatments and occupational therapy, in combination with medication. Four experimental units participated in the present implementation study. The fifth experimental unit declined to participate, due to a reorganization that was taking place. Three participating units were open units; the fourth was a closed unit. The size of the units varied between 12 and 24 beds.

Participants

Inclusion criteria for the participants were (a) being a member of the nursing staff (registered nurses or healthcare workers such as social workers), (b) at least 1 year's employment at the participating unit, (c) active involvement in the implementation of the SAM, and (d) being employed for at least 24 hr/week, to ensure continuity of participation. The participants were informed orally and in writing about the study. All participants gave written informed consent. For the allocation of patients to the nurses, no formal procedures were applied. In most cases, the primary nurse carried out the intervention. Per unit, three to six nursing staff members were trained to carry out the SAM, depending on the size of the unit.

Implementation of the Systematic Activation Method

We developed the SAM as a structured 7-week module based on the "Coping with Depression" course (Cuijpers, 2000). The aim of the intervention is to increase patients' awareness of the positive influence of pleasant activities on their mood. The course consists of six consecutive themes. These are summarized in Table 1. The patient receives a course book outlining the rationale of the intervention, practical instructions for its execution, and the schedules to fill in the homework assignments. The patient records his or her mood on a daily basis and has weekly meetings with a nurse to discuss mood, the progression of the execution of the intervention, and possible problems. A nurse coaches the patients individually once a week. These coaching sessions last about 45–60 min per session. The execution of the SAM is described in more detail elsewhere (Clignet et al., 2012).

The SAM was implemented using the following strategies:

- Before actual implementation, the intervention was introduced to the nurses from the experimental units in information meetings.
- These meetings were followed by a brief training program, which consisted of two 4-hr sessions. The principal investigator (FC) conducted the training. The first

Table 1. An Overview of the Systematic Activation Method

Theme	Activities	Interval
Theme 1: Monitoring the mood	<ul style="list-style-type: none"> • Introduction to the treatment rationale • Exercise on monitoring the patient's mood 	One session in 1 week
Theme 2: Selecting positive activities	<ul style="list-style-type: none"> • Selecting 5–15 activities from an existing list with potential pleasant daily activities • Executing these activities in the following week 	One session in 1 week
Theme 3: Plan your mood in advance	<ul style="list-style-type: none"> • Developing and executing a pleasant activity plan 	Two sessions in 2 weeks
Theme 4: Who is helping me?	<ul style="list-style-type: none"> • Defining who are able to help the patient stay engaged in activities 	One session in 1 week
Theme 5: The activity experiment	<ul style="list-style-type: none"> • Defining an activity which is difficult to carry out • Develop a plan and execute this activity 	One session in 1 week
Theme 6: Evaluation	<ul style="list-style-type: none"> • Evaluation of the intervention • Defining the possibilities and pitfalls 	One session in 1 week

meeting consisted of an introduction to motivational techniques. During the second meeting, the nurses were instructed how to execute the SAM in combination with the motivational techniques. All nurses who participated received a SAM manual.

- During the actual execution of the SAM intervention, FC visited the units once every 2 weeks to monitor the progress of implementation and discuss the barriers to successfully implementing the SAM on the ward. Furthermore, the nurses could contact FC by e-mail or telephone if difficulties arose.

Data Collection

Data were collected at unit level. To obtain broad and in-depth insight into the factors that affected the implementation of the SAM, we used a stepwise approach. First, a short questionnaire was sent to all the participating nurses. The questions are displayed in Table 2. The results from these questionnaires were used for the group interviews. To maximize participation, the interviews took place at the participating units. The second author, who has extensive experience in qualitative research methods, moderated the

Table 2. The Participant Evaluation Form

Evaluation Form SAM Participants

In general, what are your experiences in working with the SAM?
 Answer:
 How did you experience the training beforehand, and the support during the execution of the SAM?
 Answer:
 How was the collaboration with the patients during the implementation of the SAM?
 Answer:
 Which organizational factors affected the implementation?
 Answer:
 What would you change in the implementation of the SAM if you were in charge?
 Answer:

interviews. The first author, being the principal investigator, was also present during the interviews, making notes and monitoring the interview protocol, which was developed for this study. Each interview started with a general introduction, followed by exploring the process of implementation, with particular emphasis on barriers and facilitators on the level of the patient, the nurses, and the organization. Four interviews were held (one per unit). The interviews were conducted in groups.

All interviews were audiotaped and transcribed verbatim. The data were gathered between March 2012 and June 2012. The duration of the interviews varied between 46 and 68 min.

In addition to these interviews, we determined the actual implementation status on each ward. Therefore, we used a patient evaluation form, on which the patients who received the SAM intervention reported the extent to which they had carried out the SAM with support from their nurse. The 10-item questionnaire consisted of two questions regarding the number of meetings and the duration of these SAM meetings; six questions in which the patients evaluated the different steps of the intervention; and two questions in which the patients evaluated the extent to which the SAM contributed to their recovery.

Patient characteristics concerned age, sex, days of admission, former episodes of depression, level of depression, and cognitive functioning.

Level of depression was measured using the Dutch version of the Beck Depression Inventory (BDI; Van der Does, 2002). This is a 21-item self-report scale. Each item can be scored from 0 to 3. The cutoff scores are 0–13 (minimal depression), 14–19 (mild depression), 20–28 (moderate depression), and 29–63 (severe depression).

Level of cognitive functioning was measured using the Minimal Mental State Examination (MMSE; Zigmond & Snaith, 1983). The MMSE comprises 11 questions regarding

Table 3. Characteristics of the Participants

Characteristics		<i>n</i> = 12
Gender (<i>n</i>)	Female	9
	Male	3
Level of education (<i>n</i>)	Registered nurse (RN)	6
	Bachelor of science in nursing (BSN)	4
	Social worker	1
	Clinical nurse specialist	1
Professional experience (years + range)		16.8 (2–40)
Working on the ward (years + range)		8.25 (2–26)

memory, language, and attention. The maximum score is 30, and a cutoff score of <24 is regarded as an indicator for cognitive problems.

Data Analysis

For the analysis of the data, thematic content analysis was applied (Elo & Kyngäs, 2008), making use of the MAXQDA-11 software for qualitative text analysis. The primary researcher (FC) conducted initial data analysis. First, all interview texts were read several times, and relevant passages were coded provisionally. Based on these provisional code words, a preliminary code tree was constructed in the MAXQDA-11 database and organized according to the previously mentioned levels of analysis, that is nurse-, patient-, and context-related factors. Next, the interview texts were imported in MAXQDA-11 and relevant text fragments from the interviews were coded. During the coding process, new code words were constructed and existing code words were renamed or relocated, based on new insights obtained during the process of analysis. These codes were analyzed by two researchers (FC and BvM) independently, and differences in coding were discussed. After coding the interviews, all text fragments belonging to one code word were discussed and reanalyzed by the two researchers. The factors that contributed to or hampered the implementation of the SAM were extracted under the nurse-, patient-, and contextual categories.

Results

Participants' Characteristics

The questionnaire that was distributed prior to the interviews was returned by eight of the 12 nurses. All 12 nurses participated in the interviews. Per unit three nursing staff members participated. The characteristics of the participants are summarized in Table 3.

Table 4. Patient Characteristics

Characteristics		<i>n</i> = 26
Age (years ± <i>SD</i>)		73.7 (7.5)
Gender (%)	Female	57.7
	Male	42.3
BDI score (<i>SD</i>)		30.2 (10)
MMSE (<i>SD</i>)		27 (2)
Admission days (<i>SD</i>)		47 (22)
More than one depressive episode (%)		85

Implementation of the SAM

The characteristics of the patients, with whom the intervention was implemented, are summarized in Table 4. Of these patients, five dropped out early owing to lack of motivation (19%). From the remaining 21 patients, we received 15 evaluation forms (71%). They participated in the SAM for 5.5 weeks on average (range 3–12 weeks) and averaged four meetings with their nurse (range 0–10 meetings). There was one patient who had zero meetings. She reported that she executed the SAM independently.

Factors Related to the Nursing Staff

Attitude Toward the Intervention. At the outset, most participants believed the SAM to be a useful intervention, which appeared easy to carry out. They had confidence in their ability to do so effectively. The participants understood the treatment rationale. They were already using activation in their daily routine, but not in a systematic manner as prescribed by the SAM. The structured and systematic approach was considered to be the most innovative aspect of the SAM intervention as exemplified in the following discussion between two participants:

- R1: With the SAM, I am more aware of what I am doing. Normally I act routinely.
- R2: I agree with R1: The SAM is more of a guideline to me, it is well structured. When I think about it, we were already activating the patients but not as consistently as we did with the SAM. We already discussed with the patients what they would like to do in the future. Now it is clearly written down in black and white.

Some participants, however, were less optimistic about the SAM. They doubted if the intervention would be beneficial to their patients.

Intervention Fidelity. Most of the participants made substantial efforts to execute the intervention as thoroughly as possible and felt helped by the structured procedure, as this quotation illustrates:

This man was intellectually disabled and very depressed, very negative, so he really wanted nothing anymore. I tried to use the method together with him. However this stagnated at some point. If I think back, I guided him for a long period of time, while I would have stopped much earlier without a structured intervention, especially with this man.

During the actual implementation, the participants found that the intervention was not as easy to carry out as expected in most of the patients, which jeopardized intervention fidelity in a number of cases. The efforts to persuade the patients to engage in positive activities did not always lead to the expected results as this quotation illustrates:

It took a lot of energy. I don't mind if it costs me energy but eh I had to put considerable investment into it ... and the effect was low.

It was important that the efforts showed some results, such as satisfactory completion of the homework assignments or the patients' awareness that positive activities would lead to improved mood. In particular, the latter aspect also increased mutual motivation to persevere with the SAM. One participant stated:

It is important that they (the patients) have a positive experience as a result of the execution of the intervention as soon as possible. It doesn't matter how small it is, as long as it something we can use together (nurse and patient), as an extra motivation to continue the SAM intervention.

This citation underpins the importance of mutually experienced effects as a motivator.

Furthermore, despite the coherent nature of the SAM, in some cases the execution of only a small number of its components was achieved when execution of the complete intervention protocol was not attainable. The following discussion between two nurses illustrates how the SAM was adapted to individual patients:

- R1: Well, I used only parts of the SAM. I left out some of the themes because these were too complicated for the patient, although I think these parts could be useful for this patient.
- R2: Yes, you can use the SAM intervention as a whole, but for some patients it is better to use it [the SAM] in a more flexible way and improvise.

Knowledge and Skills. Nearly all the participants completed the training program prior to the implementation. Only one participant missed one of the two training sessions. The training was regarded as useful and the content easy to understand. According to most participants, the use of

motivational techniques was already part of their basic skill set. Some participants, however, reported that additional training was advisable because of the specific skills required to carry out the motivational techniques in patients with LLD. In the actual implementation, the participants relied more on their implicit knowledge, which is a blend of experience and intuition. The following quotation is a representative example of how the participants rely on their (implicit) clinical judgment:

It goes without saying, I just sense it, if someone [a patient] doesn't want to get out of bed. You become more forceful in a natural way, instead of using motivational interventions, it is a specific feeling.

The Therapeutic Relationship. The participants regarded a poor therapeutic relationship as the main barrier to successful implementation of the SAM intervention. Therefore, they made considerable effort to establish a good relationship with the patients, in which "trust" is a keyword. The participants endeavored to gain the patient's trust by empathizing with the patient's suffering. But at the same time, the SAM required active participation by the patients themselves. The discrepancy between the two interests often led to increased stress on the therapeutic relationship. Most participants believed that it was necessary to adopt a more forceful attitude with the patients. Only then could they break the vicious circle of depression, in which a lack of activities leads to an increased level of depressive symptoms, which, in turn, leads to more inactivity. Therefore, the activating aspects of the SAM were used, even when the patient was reluctant to cooperate. This regularly led to one-way communication in the relationship between patient and nurse. The consequence of this was that the nurse adopted a commanding and steering role and the patient a passive and resistant one. This inequality in the relationship became highly visible during the execution of the SAM and reinforced the participants' skepticism toward the intervention, hampering further implementation.

Factors Related to the Patient.

Severity of the depressive disorder. When depressed patients are admitted to a psychiatric inpatient care unit, they usually exhibit extremely passive and dependent behavior. All participants agreed that implementation of the SAM was not possible right after admission. Treatment was limited to medication and following the daily routine at the unit. The following quotation is a representative example:

The patients who are admitted, especially nowadays, are not able to remain at home anymore, despite all the ambulatory care. The patients are too depressed and

not even capable of rating their mood, they have no energy at all.

According to the nurses, the cognitive impairments, as a consequence of LLD, such as temporary memory loss and diminished concentration, made it difficult for some of the patients to engage in the active execution of the SAM. These patients experienced the SAM as an obstacle, and it confronted them with their inabilities.

Most patients were more accepting regarding active participation in the SAM after the most severe depressive symptoms receded. The participants found that a reduction of depressive symptoms increased the patients' hope and belief in their recovery, as this quotation illustrates:

She [a patient] was motivated. She got through the most serious episode of her depression and was motivated to do everything that would help her. First, she was very depressed but at a certain point she realized that she actually could recover from her depression and from that point on her mood improved.

Personal Characteristics

Apart from the depressive symptoms, some patients' characteristics turned out to be obstacles to the implementation of the SAM. The participants noticed that some exhibited dependent behavior, which they attributed to low self-esteem. For these patients, the amount of reading material and exercises seemed overwhelming, and they had no confidence that they would be able to complete them. This increased these patients' reluctance to engage in the SAM.

Age-related factors hampered the implementation of the SAM in two ways. First, the patients tend to use their age a priori as an excuse not to cooperate actively in the intervention. This quotation typifies the participants' powerlessness when age is used as an excuse:

Yes, there were people who said 'I'm 80 now, must I still do a course? I'm not going back into the classroom,' things like that.

A traditional view of the treatment of depression hampered the implementation of the SAM, as this discussion between two nurses shows:

- R1: Well I wonder because they [the patients] are generally, in my experience, more passive and dependent on the doctor "who knows it all."
R3: The doctor is placed on a pedestal.

Second, some participants deliberately took the patient's age into account when implementing the SAM. They reported that they felt compassionate and tended to be less strict with older patients. For example, they did not ask them

to complete their homework assignments. Moreover, some participants felt encumbered in implementing the SAM in elderly patients due to the age differences, as this quotation illustrates:

Sometimes I felt uncomfortable as a younger person, about guiding a patient who is the same age as my grandfather through a course [the SAM].

Factors Related to the Context. The context in which the SAM was implemented was described as highly dynamic. The 24/7 admission function of the units made it difficult for the participants to implement the SAM on a regular basis because of the high turnover of patients and the unpredictable nature of the disorders in some of their patients. Furthermore, the irregular shifts often led to lack of continuity. To optimize continuity, the SAM was transferred to colleagues when necessary as this quotation illustrates:

For many of my shifts, the patient was at home for the weekend or followed his rehabilitation program and it was difficult to find time, literally, so I worked together with P [name of colleague].

Finally, execution of the SAM turned out to be a complex and time-consuming activity, which resulted in an additional workload.

Although the nursing staff members were loyal to each other, they sometimes felt awkward about leaving their colleague with the other patients in the unit while executing the SAM, as this quotation shows:

Sometimes I felt that I had to be accountable to the other team members—that I had to explain what I was doing.

The above citation also indicates the importance of a positive attitude within the nursing team regarding the extra time necessary to implement the SAM within existing routines. In three units, the participants indicated that it was easy for them to discuss issues regarding the implementation throughout their shifts and at the changeovers. In one unit, however, it was difficult for the nurses to discuss their implementation issues because these nurses worked alone.

The participants addressed nearly all the problems, such as lack of time or problematic patient characteristics and tended to discuss and solve these problems and issues within their own team. Less attention was paid to their problems in the therapeutic relationship. This became evident in the involvement of the principal investigator. Although the participants considered the regular supervisory visits by the principal investigator as useful, they rarely used these visits to discuss complex cases.

Multidisciplinary collaboration in the implementation of the SAM depended to a large extent on the efforts of

the unit managers. In two units, the managers facilitated multidisciplinary collaboration by integrating the SAM in the existing multidisciplinary meetings such as morning reports and treatment plan meetings. Participants reported that multidisciplinary involvement was helpful when patients were extremely difficult to motivate and where there were concerns about the fruits of their efforts. The nurses characterized the role of the multidisciplinary team members as advisory.

When managers did not facilitate multidisciplinary involvement, the nurses sometimes experienced frustration due to the fact that it was unclear to them how to discuss these complex cases in the multidisciplinary team. The following quotation illustrates this frustrating process:

Yes, maybe I should discuss it with B [name of the manager] but I don't know if it is my job to discuss this. At a certain point, when it didn't work out with a patient, I discussed it with the members of the treatment team and they were cooperative, but after a week it wasn't an issue any more, as if it had disappeared into thin air.

Discussion

To our knowledge, this is the first study in which the implementation process of a research-based intervention in old age mental health nursing is described. The results of the interviews show that there are several factors, which contributed to a successful implementation of the SAM in daily practice. Contributing factors are (a) a positive attitude among the nurses, (b) adaptation of the intervention to the specific circumstances of the patient and his/her context, (c) a supportive nursing team, (d) integration of the SAM in the multidisciplinary treatment plans, and (e) active involvement of the unit manager in the integration of the SAM in the multidisciplinary treatment. On the other hand, there are several factors, which hampered the implementation of the SAM. These factors are (a) the complexity of the intervention, (b) lack of time, (c) the severity of the MDD, and (d) patient-related factors such as dependent behavior, cognitive impairments, and patients' beliefs. Although these factors were also found in other studies (Francke et al., 2008; Wensing et al., 2014), our research shows that the patient-related factors in particular were challenging for the implementation of the SAM in mental health nursing. Owing to the specific nature of the psychiatric disorder, that is, LLD, patients' motivation to engage in activities was already low beforehand, leading to reluctance to participate.

A study comparable to ours is the Behavioral Activities Intervention (BE-ACTIV) study of Meeks, Looney, Van Haitsma, and Teri (2008), in patients with LLD in nursing homes. In this study, a mental health practitioner

implemented the treatment program (BE-ACTIV) in close cooperation with nursing staff members. This study shows, in line with our findings, that adapting the execution of the intervention to the specific patient characteristics and contextual situation improves the chances of successful implementation. Furthermore, the Meeks study showed that a positive attitude among the staff members, as well as the support of and cooperation with other team members contributed positively to the implementation process. Similar results were found in our study. A lack of time among the nurses and patient's refusal were factors that negatively affected the implementation in the Meeks study that are in line with our results. Although the studies show similarities, it is noteworthy to mention that the settings differ, as does the severity of LLD in the participating patients. This might explain why patient characteristics and severity of depression affected the implementation negatively in our study, but not in the study of Meeks et al. (2008).

To stimulate the patient to engage in the activation method, the nurses placed considerable emphasis on establishing a therapeutic relationship, which they considered to be a pivotal element in the activating treatment of the patients (or, as the nurses stated, a major barrier when the relationship was poor). This is also discussed extensively in other studies. A study by McCabe and Priebe (2004) shows that the therapeutic relationship is a reliable predictor of patient outcomes. Cahill, Paley, and Hardy (2013) recommend that nurses keep a focus on the therapeutic relationship, as their study shows that patients regarded the therapeutic relationship as the most helpful regardless of the type of therapy (i.e., psychodynamic interpersonal therapy vs. cognitive behavioral therapy).

During the actual implementation of the SAM, the nurses noticed that the intervention method was more complex than they had assumed in advance, this despite the fact that the nurses had considerable experience with the patient group. It took a lot of time and effort to implement the intervention within the daily routine of the unit, which sometimes led to frustration. Only a few nurses acknowledged beforehand the difficulties in carrying out the SAM, particularly with respect to motivating the patients with severe depression. This is in line with the findings from the study of Paley Shapiro, Myers, Patrick, and Reid (2003), where the nurses were surprised and frustrated with respect to their experience that what seemed simple during the training period proved to be complex in actual clinical practice. Puentes (2003) argues that a clear understanding of the psychotherapeutic approach and the skill level of the practitioner will enhance the treatment outcomes. Although most nurses in this study considered their motivational skills to be sufficient, the complexity of carrying out motivational techniques to patients with LLD became highly visible. In keeping with Puentes' arguments, more emphasis on motivational techniques in the training

as well the supervision meetings might have led to a more effective implementation of the SAM. Although all patients gave informed consent to participate in the intervention program, it is possible that some were unaware of the effort required, leading to demotivation, which hampered (or delayed) further implementation. According to the participating professionals in the present interview study, the SAM was not suitable for all patients. Maybe, in line with Puentes, more attention should be paid to assessing the patients for their motivation and necessary skills to effectively participate in the intervention program, with the likelihood of better treatment outcomes.

In most of the cases, the SAM was adjusted to the individual preferences and skills of the professionals, the preferences of the individual patients, and contextual circumstances.

Initially, the SAM was presented as a highly prescriptive intervention, but during the implementation process the nurses used it in a more flexible way. This means that the nurses only used the elements that were regarded as useful. This probably explains the variation in the dosage of the intervention the patients received. In these adjustments, the nurses relied on their professional knowledge, experience, and intuition. However, in many cases it remained unclear what the underlying motives were for the adjustments they made. Their tailored methods sometime contradicted the structured and systematic approach of the SAM, which was meant to guide clinical decision-making in a clear and transparent manner (see also MacNeela, Scott, Treacy, & Hyde, 2010).

In conclusion, of the wide range of factors that affect the implementation of innovative therapies, certain factors impact every setting or patient group to a greater or lesser extent. Our study shows that the therapeutic relationship is the cornerstone of nursing care and therefore should be the starting point in the implementation of new therapies, such as the SAM, in inpatients with LLD.

Limitations of the Study

This study has a number of limitations. First, although all the healthcare professionals we interviewed were part of the nursing team, there were differences in level of education, which could have influenced the implementation process in separate cases. We have tried to minimize the influence of these differences by developing the SAM as a highly prescriptive intervention, suitable for registered nurses at bachelor level or higher, but also for other team members. They all underwent the same standardized training program. Furthermore, one of the inclusion criteria was working experience of at least 1 year with the target group, to ensure sufficient experience and skills in all the participating professionals.

A second limitation is that the results are based on a relatively small sample of 12 participants, and therefore transference of the results to all mental health nurses requires caution. As this is an explorative study, further research is highly recommended in this patient group to strengthen the knowledge base concerning the implementation of complex nursing interventions in mental health care.

Implications for Nursing Practice

This study has highlighted the complexity of the implementation process of research-based interventions, such as the SAM, requiring integration of scientific evidence, professional expertise, and patients' experiences and preferences. Careful supervision and monitoring of these implementation processes is necessary, as is the active participation of management and the multidisciplinary team (see also Puentes, 2003). A thorough analysis must be made both before and during the process of implementation of (possible) barriers and facilitators for successful implementation on the level of content and complexity of the intervention, the patient group, the nurses, the nurse–patient interaction, and organizational factors. Targeted influencing of these barriers and facilitators may contribute to more efficient and effective implementation of the intervention.

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